PATIENT DENTAL HISTORY

	YES	NO
1. When was your last dental exam?		
2. When was your last full mouth X-ray taken? Where?		
3. Have you had trouble from previous dental care?		
4. Do you have pain in your jaw or near your ears?		
5. Do you have any unhealed injuries or inflamed areas in or around your mouth?		
6. Have you experienced any growths or sore spots in your mouth?		
7. Does any part of your mouth hurt when clenched?		
8. Have you ever had Novocaine or other local anesthetic?		
9. Have you ever had Nitrous Oxide (laughing gas) or General Anesthesia?		
10. Any reaction or allergic symptoms to Novocaine, local or general anesthetics?		
11. Any difficult extractions in the past?		
12. Prolonged bleeding following extractions in the past?		
13. Do your gums bleed?		
14. Do you have a bad taste in your mouth or mouth odor?		
15. Have you ever had instructions on the care of your gums?		
16. Do you chew on only one side of your mouth? If so why?		
17. Do you habitually clench or grind your teeth during the night or day?		
18. Any part of your mouth sensitive to pressures or irritants (hot, cold, or sweets)?		

SIGNATURE DATE